MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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COMMISSIONERS PRESENT:

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MARY K. WAKEFIELD, Ph.D.
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AGENDA ITEM:
Purchasing strategies - Anne Mutti, Jill Bernstein

MS. MUTTI: Today we will present our workplan and initial findings for a project we're calling purchasing. As it has been alluded to, this will naturally build on what you've just heard. As Kevin mentioned, the particular strategies we are focusing on here are those that improve efficiency, and by efficiency we mean reducing spending while maintaining or ever improving quality of care.

Our plan here is to first identify a range of strategies being used by private-sector purchasers as well as other public purchasers. And then second, to examine whether of them could be applied to fee-for-service Medicare. Again this builds on just the conversation you've had here except that we're looking at a broader range of services, not just imaging services.

We think this research agenda may be useful to policymakers for a couple of reasons. It recognizes that a majority of the beneficiaries are expected to stay in fee-for-service, even with the reform legislation that just passed. Also we think that pressures to contain Medicare spending growth are likely to increase, not decrease, especially given the continued growth in health care costs and the impending retirement of baby boomers.

This approach also responds to commissioners' requests for information on private-sector practices related to containing physician volume growth. So hopefully we'll give you some examples there.

As I said, it relates to Kevin's work on imaging. This work also relates to Karen's work and the Commission's work in the past on quality of care. Certainly quality and efficiency may go hand-in-hand. But there are aspects to efficiency measures that I think deserve a more focused approach to looking just at efficiency.

This work also builds on our exploration of Medicare demonstrations that improved efficiency in fee-for-service, and those were the centers of excellence and competitive bidding in durable medical equipment that we talked to you about the last year.

Our first step in this project has been to conduct interviews, and today and in April we plan to focus on summarizing our findings from those interviews and begin to consider what some of the issues might be for Medicare to undertake some of these approaches. We plan to come back to you then in the fall with more specifics on what some of those options could look like.

To date we have interviewed people in 13

organizations, including four purchasers, five health plans, and four benefit consultants. We have asked them to identify the array of approaches they have undertaken and some of the implementation issues that arose in those strategies.

Let me first note a couple of caveats in this summary. First, we looked at people who were innovators, so they might not necessarily be representative of the whole market. Our findings may not, therefore, what the norm is.

Also, this is an interim report so we expect that our future interviews over the course of the next month will help round out our understanding of what's going on out there.

In general, our interviewees identified strategies that were directed at three drivers of health spending, volume of services, productivity in delivering those services and the price for those services. We'll present the strategies with that organizing theme in mind, but we certainly recognize that the strategies do overlap the themes. It just seemed helpful at the time.

So let me start with volume strategies. By far the type of volume strategy that we've heard most about is directed at identifying efficient provers and improving provider efficiency. As motivation for this approach many of our interviewees mentioned the Fisher and Wennberg work on geographic variation in health care services. They also mentioned research showing that both high-cost and low-cost providers are able to offer quality care.

At a minimum, this approach involves measuring the relative efficiency of provider or provider profiling. We've heard some of that this morning. Approaches varied on a number of dimensions. First, plans differed on who they profiled. Most of the plans that we spoke to really focused on profiling physicians. Among them, some of them both profiled both primary care physicians and specialists. Some focused on one or the other. Some also focused on profiling hospital services, and within that they might profile the whole hospital's performance or they might focus on selected services that they were very interested in. We did hear about them profiling radiology services like we heard this morning.

The measures of efficiency varied largely by the type of provider that they were profiling as well as if they were profiling an individual or a group. In general, the themes that we heard were that people were interested in using claims-based data for administrative ease in their profiling. They were intending to do the best job they could on adjusting for case mix. They also seemed to be interested in moving to measuring care over an episode, not just an individual unit of service.

Along those lines, several were using commercial software products that measured physician efficiency by comparing what expected utilization would be to what actual utilization would be. One plan we spoke to also looked at whether certain surgeries were necessary to begin with. So that rather than measuring efficiency once the episode was triggered, they examined whether the episode was necessary to begin with.

For primary care physicians, plans used measures such as total cost of patient care, referral patterns, use of generic drugs, admissions to the ER. For hospitals, measures tended to be total costs and mortality rates associated with a particular episode.

Opinions varied on the validity of these measures, particularly so with respect to the software that was measuring these episodes. Some were concerned that it did not do an adequate job in adjusting for case mix. Some felt that they could not adequately assign patient costs to a particular physician, particularly primary care physicians so we're only using this software for specialists.

Another issue that came up repeatedly was the need for adequate data. I think we heard that this morning, that you had to have adequate claims in a given marketplace to make this work. Some plans were restricted in which markets they could do this profiling even though they felt that it was quite effective. So repeatedly we heard from people the request that Medicare make their claims data available to them so that they could do a better job profiling.

Nearly everyone indicated the need to have both quality and efficiency data; that that would be the optimal way to profile people. Some of the plans seemed to think they had a decent handle on that, were coming the two together well. Others did not feel that way. In fact one plan asked us to give them a call back if we came up with any really good ideas.

Most acknowledged that profiling had the potential to cause tension with providers who were being profiled. Some had been doing it for years. They didn't feel that it was such an issue anymore. They had overcome most of the obstacles. Other plans were a little bit more new to it and they were encountering resistance. But I think we heard a couple of themes from everyone that a few things could help make providers more responsive to profiling. One was that the profiling criteria should be transparent. That everybody should be able to understand what they were being measured against; it should be publicly available.

Two, if they could see how actually patient care could be improved as a result of the profiling they were more comfortable with it.

And three, if the profiling was to be paired with

incentives, and we'll get to that in just a moment, that those incentives should be positive ones. I think that was reflected this morning also.

So this brings me to a discussion about incentives. Certainly information disclosure is one incentive that you could pair the profiling with then disseminating that information. Nearly every plan we spoke to fed that information back to the providers. I would say that quite a few felt that it was pretty effective. That they did find that providers responded to the comparison to their peers. A couple seemed to think it was particularly effective if they could see how it was directly related to adhering to evidence-based practices, especially those -- if they could compare whether they were meeting the diabetic or asthmatic criteria and felt that their patient care could be improved as a result of measuring up, they were more likely to change their behavior.

For disclosing this information to beneficiaries, it seemed that more plans were more inclined to disclose quality oriented information to beneficiaries, less so efficiency. One of our interviewees mentioned that they felt that beneficiaries would need some education on how to interpret efficiency information. That there was a perception that more services were better, and that that might need to be clarified.

Some plans also felt that the profiling needed to be combined with financial inducements in order to be more effective. This might be financially rewarding providers who provide more efficient care and/or beneficiaries for selecting more efficient providers. One example of this is creating tiered networks of care where profiling results are used to assign certain providers into tiers, each of which might have beneficiary cost-sharing or provider payment implications. Plans use different calculation methods to assign providers to tiers and seem to value the flexibility that they had in different markets to make different determinations as to what the criteria would be for each tier.

Some plans were also using profiling information to designate centers of expertise or centers of excellence. They usually focused on high-cost procedures, some did transplants and then just picked one national center or several national centers and their benefit only covered care in those centers. There was no out-of-network benefit for those services. Others were interested in creating centers of excellence for cardiac, cancer, orthopedic surgeries that were in different markets around the country. There would be an out-of-network benefit for not going to those centers for those services.

Another type of financial inducement is to share

the savings resulting from the reduced volume between providers and the insurer or purchaser. This may be a bonus payment being paid to providers who are able to have actual costs for an episode that are below what the expected costs would have been.

In addition, another incentive is to selectively contract with certain providers and create an exclusive network. While most reported that they were keeping their networks broad, some did say that the employers that they were working with were interested in exclusive networks and they were planning on developing those type of products.

Other volume oriented strategies focused on paying for appropriate care regardless of the relative efficiency of the provider. They included preauthorization requirements and coding edits, both of which we heard today. I guess one thing I'll just add on preauthorization requirements, we heard that some plans had curtailed using them. They felt that they had antagonized providers and they were holding back on that. But we certainly heard at least from one about that they were reinstating their preauthorization requirements. They had gone too far in cutting back on them and they couldn't afford to lose those savings that they had been getting with them.

I won't say anything more about coding edits. We also heard about trying to address consumer demand for health care services. Again, I think we heard about that this morning too.

The one thing I'll add though is that in addition to these wellness programs, informing people how to manage their conditions, having self-assessments on an Internet program, there were also these decision-support programs. These programs are designed to help beneficiaries choose between treatment options and be better informed about their expected care. One purchaser told us that what they did is they allowed individuals to decide sometimes to choose a less invasive option rather than the more invasive option of care, and then they were better prepared to follow along their course of care and maybe catch something that was being missed and just better manage their care. They felt that this was a very effective way of controlling demand and volume for services.

Another subset of strategies, attempt to encourage providers to change the cost of production, or reduce the number of resources required to deliver the same unit of services. In some cases this may also reduce volume.

Examples here include hospitalists and intensivists. Almost everyone we spoke to had high praise for this approach. These are specialists trained to handling inpatient or, in particular, intensive care unit care. They seemed to be saving a fair amount of money and

reduce length of stay.

One plan adjusts surgeon's payments if they select a less costly site of service in which to perform their surgery. A few plans also indicated that they bundled for hospital and physician services for transplant surgeries. But otherwise it seemed that most payers were paying providers separately on a fee-for-service basis. A few that used to capitate physician groups were no longer doing so.

We found that while payment itself seemed largely unbundled, the providers and managed-care plans were increasingly being held accountable for a bundle of services surrounding an episode of care, as we talked a with profiling, so that their ability to hold costs of an episode down might be rewarded by bonus payments or by a higher fee schedule. So in some ways there's almost like a shadow bundling going on.

We did hear from one integrated delivery system that they felt constrained in their ability to induce physicians to cooperate to hold down hospital costs. This provider mentioned that they thought that they might have a problem with drug-eluding stents, that they were being overused. He approached one of his cardiologists to ask them if they would help identify ways to reduce overuse, and the cardiologist responded that it wasn't his problem; it was the hospital's problem; not his cost. The executive felt that he was constrained by gain-sharing, in creating gain-sharing incentives by the anti-kickback laws that exist that present this kind of arrangement.

A few plans discussed strategies they used to improve the price they pay for services. These include competitive bidding, and these were used for laboratory, specialty pharmacy services as well as durable medical equipment. Generally they reported that they got significant savings out of this benefit but sometimes it was labor-intensive, creating such a formal bidding process.

A number of plans also indicated that they adjust their price if multiple services are performed at a single encounter. That mirrors what we heard this morning on imaging services.

Tiered networks, in a sense, are also a type of pricing strategy. Plans or purchasers can accept the price offered by providers but based on that price assign them to a lower tier that's associated with higher beneficiary cost-sharing. Indeed, providers may respond to that threat by reducing their price.

Those are the types of things that we encountered on price. Let me go to next steps here.

As I mentioned, in the next month we plan to conduct more interviews, add to our summary findings information from the literature review, and begin to broach

the opportunities and challenges in applying these strategies to Medicare fee-for-service. Then we plan to come back to you in the fall for some discussion of how they might be applied to Medicare fee-for-service.

I will turn it over to Jill now for an update on Medicare contracting reforms and at the conclusion hope to get your feedback on the array of strategies we've identified here. Those that you're more interested, would like more information on.

DR. BERNSTEIN: Clearly, assessing whether there are purchasing strategies that could or should be incorporated into Medicare is going to involve a lot of discussion. You've already had some of that discussion start here today. But to set the stage I'd like to direct your attention to something that's actually new in the discussion, and the key point here is that the new legislation has changed what the Medicare program is allowed to do as a purchaser.

Briefly, the MMA eliminated provisions that restrict the Secretary's contracting authority in the Medicare program. The new law removed requirements that claims processors be nominated by broad organizations. It eliminated some provisions that made terminating contracts harder. And it ended the requirement that Part A and Part B contractors have either only pure Part A or pure Part B contracts. And it also eliminated the provision that they had to do the full range of things that a contractor has to do as a claims administrator.

Under the MMA reforms, the existing fiscal intermediaries and carriers will be replaced by Medicare claims administrators called MCAs. The new contracts will, with certain exceptions, be completed under the regular rules of the federal acquisition system. Not that these are the most nimble things in the world, but they're a lot different than what they had before. The transition to the new contracts will begin on October 1, 2005 and it's to be completed by September 30th, 2011, so we have a little bit of time. The statute specifically requires the Secretary to develop performance measures and standards and to incorporate these performance standards into these new contracts with the contribution of physician and provider organizations and beneficiaries organizations in developing the performance requirements.

The new provisions could provide some opportunities for Medicare. First, the pool of contractors should expand, allowing the organizations with special expertise, like some of the places we've been talking about today, to compete for Medicare contracts. This could be by service or, for example, there are now special home health contractors. We could do that for other services in theory,

or they could contract with organizations with special expertise in things like post-payment review or prepayment review. This could also provide CMS with an opportunity to review the various activities of its other contractors, including the quality improvement organizations and the program integrity contractors as well as the new claims administrators, to determine how the various activities involving profiling and analyzing payment and utilization might be better coordinated program-wide.

Second, the focus on contractor performance standards could provide more impetus for CMS and the contractors to focus on strategies to inform providers about effective practice, or to devise more effective claims screening protocols, et cetera.

I will try to answer any questions about that or we can turn to them more broader issues that we've been discussing.

DR. REISCHAUER: Thank you.

DR. ROWE: Anne and Jill, I found this very helpful and I thought your presentation was very articulate. I have a number of points I'd like to make about the tiering issue which I hope are helpful. First, I think the description of tiering in the chapter could be beefed up a bit. You have it on page 10, and with respect to hospital tiering I would refer you to an article in Health Affairs by Jamie Robinson, a professor at Berkeley that was a year or two ago where he talked about different approaches that health plans have to tier hospitals and he has an example of High Mark and of the Tufts Health Plan, of Wellpoint and a couple different strategies that have been used or not used. I think it's a nice articulation of an approach so I would refer you to that.

Secondly, I would refer you to the Leapfrog Group which I think is going to come out shortly with a new approach to tiering. So you should check with Suzanne Delbanco or Arnie Milstein at Mercer who I think may be working with them on that. So that by the time this comes out, we want to be informed of what they're doing so we can be up-to-date, because I think this tiering strategies may be the brave new world for Medicare and it would be very interesting to have a little more information about that.

With respect to the Pitney Bowes experiment which you refer to towards the end of the chapter, I think it would be worthwhile -- you are going to ask some questions about why it ended. Because you talk about how successful it was and you noted it went for two years. The question is why did it end. I think there's some political lessons to be learned there.

I would think that it's worth talking about the fact that one of the intrinsic assumptions that many

institutions are using to tier hospitals is that volume is a proxy for quality. There are now some data in the literature with respect to cardiac angiography, et cetera, I think from Pittsburgh, that suggests that volume may -- the utility of volume as a proxy for quality may vary by age of the population you're studying and some other factors and that may be relevant to Medicare. That's worth looking at because that is intrinsic in a lot of these tiers.

A second issue relates to pooling, and I think Medicare can be particularly important here. Many of the pooling issues that we've had so far have been by health plans who have been limited in their capacity to tier doctors because a given health plan has a small portion of the physician's practice. The physician says, you've only got 10 percent of my practice, it's not representative, et cetera. Medicare by virtue of its size and the proportion of the practice that it would have for many practitioners, if Medicare were willing to pool its data, administratively available data with health plans, we could have some sort of national pool and we could really have a very valid sense of performance.

I think there have been some concerns about privacy. You refer to them in the chapter. But it would be nice to examine what those concerns really are and whether or not we might be able to get anonymized data or something. It's not really about the individual patients, it's about the complication rates and other things. How many patients who have a diagnosis of an MI have a beta-blocker prescribed. You don't have to know the names of the patients. So I would suggest that we consider looking in that direction.

Two other final points. One is I think we should differentiate when we talk about quality, tiering for quality. Anne, you mentioned that. If you're tiering in such a way that you're removing 15 or 20 or even -- say, percent of the practicing physicians, then what you have left is a tier that is acceptable quality. We don't differentiate in the chapter and in our language high quality from acceptable quality. People seem to think when you say you have a quality network that this is like the top 5 percent of doctors. What we're not doing is identifying the ultra elite. What we're doing is removing the bad guys, and we should distinguish between those two things.

This is a tremendous among to be gained and much less political pushback from organized medicine when you eliminate the outliers on the downside, because everybody knows who they are and the rest of the doctors are happy to have them eliminated. It's not like we're taking on the medical establishment by eliminating 80 percent of the doctors. There should be some discussion about that because

I think that that's important.

And that's important to the last point, and that is that I think the utility of tiered networks is dramatically influenced by the supply of physicians. The reason Pitney Bowes was able to do it in Fairfield County, Connecticut is there was perceived to be an excess of physicians, so that they could eliminate some proportion and not have access problems. Medicare is dealing with a national situation with wide variations in the numbers of physicians. I think MedPAC, if we're talking about things like this we should be mindful and express our awareness of the intersection of any recommendations with respect to this with the issue of access and the size of the Medicare network across different sections.

Thank you.

DR. REISCHAUER: Thank you for that brief intercession.

MR. DURENBERGER: You took three of my items so maybe mine will be even briefer.

Secondly, I'm so enthused about what we're doing here that I can't come up with a superlative to compliment Mark and the staff and everybody else. I just think it's really important.

On the issue surrounding volume, productivity, price and things like that I would love to see some inclusion of the VA and all the work that the VA has done and how they've gone about doing it. I know it's a different kind of a system but I think there are ways in which -- could be extrapolated.

Secondly, the work around six Sigma, Toyota, and so forth that are being done by some of the larger probably multispecialty groups. Mayo comes to mind because I know they are doing it, and plenty of others, and what does that tell us and how does that inform the language that we use and other things like that.

Third is workforce utilization as an impediment to productivity. When I look at hospitalists and intensivists, I think in Minnesota we counted up, we now have 400-plus licensed allied health professions, something like that. The whole issue is like the role that licensure, credentialing and all of these other factors play in getting in the way of particularly clinical or system productivity. That probably a whole piece of research on its own but I just thought some allusion to it would be important.

Fourth, I would suggest that what the MMA did to prohibit cost-effectiveness study on drugs and medical devices ought to be reversed in some way and I think we ought to speak to that. I think the ability for CMS to do or sponsor cost-effectiveness studies is very important and it is just another example of the way that some of the

interest groups have made sure we couldn't work on the effectiveness area.

The next one relates to the employer, the role of employer. I think Jack alluded to the Leapfrog. The commitment that the governors made in Minnesota to these same kind of strategies begins with employers, and it's the public and private employers. So the way in which the employer combined with the work the plans are doing and the work that certain kinds of provider groups are doing probably will be informative to the work that Medicare has to do.

I think that's my list. Thank you.

MR. FEEZOR: I would like to also compliment Jill and Anne for the work. In the first section where you start out on some of the limitations on Medicare's current policy in fee-for-service, I think that could be expanded a little bit and I certainly would encourage what seems to be a history of not encouraging the individual to take better care in terms of managing their own, although arguably the new initial physical could begin to take a step in that direction.

Equally, and you talk about in a couple of different places some anecdotal comments about difficulty to do incentives across providers and gain-sharing, I think some enumeration or at least reference to that under the current policy might be helpful.

Somewhere in there there was a reference to, by providing individual's information about the quality of their provider, provider networks, there was an ability to move 3 percent per year. We probably need to be careful to make sure that that is equally applicable to Medicare as it is to commercial. My suspect would be that it is not.

Then finally, I guess I was a little surprised in your initial interviews that it didn't come out as an explicit purchasing strategy, maybe it's more under quality control, but certainly the whole movement to consumer-driven product I think is not just a cost avoidance but is an effort, a conscious effort on the part of purchasers to, by making the patient more involved, to begin to dampen the demand side. You reference that actually in the narrative but whether you want to call that out as a separate purchasing strategy is something to think about.

Then finally, I think also individuals, particularly in self-funded plans and the ability to do risk profiling is not only to, I think, try to set out care management but is a way of saying, we are going to spend our monies on a narrow segment of our beneficiary population that need that care. As a consequence I think even high risk identification and risk stratification within the beneficiaries and differing the level of care management

that you might have in that is an explicit strategy as well.

MR. HACKBARTH: This is good stuff and thank you for the work on it. I want to make sure though that we don't race into the details. I think that there might be some important threshold questions that bear discussion about whether, assuming we could change Medicare to adopt some of these practices, whether it would be a good idea to do so. It's commonplace for people to say, this or that's politically difficult and it may be unpopular with beneficiaries or with providers and that's why Medicare can't do it.

But I think there is a more basic question about whether Medicare should do it. I ask the question without having a firm opinion on one side or the other, but for a public program to undertake some of these activities, I think the consequences are different. Most basically, if a private health plan does one or more of these things and it doesn't go well, they're subject to market discipline. And if it doesn't go well, they can change things quickly, make revisions in a way that I don't think necessarily happens in the political process. The cycles of change and improvement are not as rapid, not as flexible, and the political discipline may not be as efficient in this case as market discipline is in correct errors and problems.

I wonder whether philosophically the thing to do might not be to say, we ought to operate the traditional Medicare program as a traditional free choice system with virtually all providers permitted to play and the like, and to the extent that we seek innovation of this sort, the way it ought to be made available to Medicare beneficiaries is in fact through the offering of private plans that work in a whole different environment, in some ways with fewer constraints but also with the market discipline. The beneficiaries can leave if they don't like what's happening, whereas you can't leave -- if traditional Medicare does awry we've really lost something that's difficult to replace.

So it's a question, but I think it is an important threshold question before you get deep into the details of the advantage of this approach or that approach.

DR. REISCHAUER: I think that's a good point and I would agree with much of it, but the question here is comparative cost and information on quality and you have to be able to compare the quality in the plan or the plans with the quality that exists in the traditional system. Heretofore we haven't been willing to do that. The plans themselves can come up with information about how good they are or they can use HEDIS measures or whatever. But the ability to then compare it to what you would get in the other world isn't there yet.

MR. HACKBARTH: Of course I would support that

sort of comparison. I think what you get in traditional Medicare is you get a tremendous variation in quality. It's not like it's a monolith. You can get most anything from the best in the world to the worst in the world. But certainly I'm all in favor of enhancing our ability to compare. I'm just not sure that you are really comparing anything meaningful in traditional Medicare in the aggregate, which incidentally is one of my fears about how private health plans have evolved too, to the extent that they have all-encompassing networks of providers, virtually everybody in a community, I think they have also become just a hash. Comparing the quality performance of one IPA HMO that encompasses everybody in the market to another IPA that encompasses everybody in the market is pretty a sterile exercise in my view.

MS. MUTTI: Just a clarifying question based on what you just said, Glenn. Are you comfortable with us going forward with the summary and alluding to some of those issues that raised too as to the advisability of Medicare -- are you comfortable with us producing a product like that?

MR. HACKBARTH: Yes, in fact I see this as a developing area of the Medicare debate. There are very vocal, articulate proponents of the view that Medicare ought to become a more active purchaser, like Bob Berenson. Bob and I were talking about this last week. As opposed to say, private plans are the only way to get innovation. We can do it in Medicare. I think that's a very important question to raise. I just want it framed properly.

DR. REISCHAUER: Thank you, Anne and Jill.